

Notice of Independent Review Decision**DATE OF REVIEW:** 3/12/10**IRO CASE #:****DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE**

Repeat Lumbar MRI & lumbar x-ray AP lateral Flexion and Extension

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

Certified by the American Board of Orthopaedic Surgery

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

Injury date	Claim #	Review Type	ICD-9 DSMV	HCPCS/ NDC	Upheld/ Overturned
		Prospective	724.2	72148	Upheld
		Prospective	724.2	72100	Upheld

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Correspondence throughout appeal process, including first and second level decision letters, reviews, letters and requests for reconsideration, and request for review by an independent review organization.

Physician notes dated 12/16/09, 5/6/09

X-rays report dated 6/8/09

Treatment summary

Official Disability Guidelines cited and provided-Low Back-Lumbar & Thoracic (Acute & Chronic)

PATIENT CLINICAL HISTORY:

This patient has a date of injury of xx/xx/xx. The records presented for review indicates that there is an increased complaint of low back pain, a June 2009 MRI noting multiple level degenerative changes and multiple level disc lesions. Canal stenosis was also noted.

The May 6, 2009 progress note reports complaints of low back pain and a loss of sensation in the bilateral upper extremities. MRI lumbar spine was requested.

The June 8, 2009 lumbar MRI noted old wedging of T12, degenerative changes and a retrolisthesis at L5. Degenerative changes, Schmorl's nodes and degenerative disc disease were also reported. A canal stenosis is noted at L3-4.

The December 16, 2009 progress notes complaints of low back pain, the physical therapy is helping but the discomfort is constant. It is also noted that the injured employee failed to follow the work restrictions placed upon him and that is the reason for the discomfort. The patient is noted to be on multiple medications (Darvocet-N, Flexeril, Lisinopril and Metoprolol Tartrate). Repeat Lumbar MRI & lumbar x-ray AP lateral Flexion and Extension has been requested.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

In the Reviewer's opinion, there is no clinical indication for repeating these studies based on the data presented. There are two progress notes and each notes back complaints that do not correlate. One does not have low back pain and associated bilateral upper extremity sensory changes. The June 2009 MRI objectified multiple degenerative findings that would explain the current symptoms. There is no progressive neurologic deficit and no new symptoms. As per the Official Disability Guidelines (Updated March 2010), the standards for a repeat MRI are not met.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☐ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**
- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**